



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

PegIntron® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Chronic hepatitis C	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Does the patient have decompensated liver disease (defined as Child-Pugh Class B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select if PegIntron will be used in combination with the following:	
<input type="checkbox"/> Olysio (simeprevir)	
<input type="checkbox"/> Sovaldi (sofosbuvir)	
<input type="checkbox"/> Ribavirin	
Does the patient have contraindication or intolerance to all other HCV agents (e.g., Olysio (simeprevir), Sovaldi (sofosbuvir), ribavirin)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
Does the patient have an undetectable HCV RNA level at week 24? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are additional treatment weeks of peginterferon required to complete treatment regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient exceeded 48 weeks of therapy with peginterferon? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
 Office use only: PegIntron_Comm_2018Dec-W